MONTANA MEDICAID TEAM CARE REFERRAL FORM

Team CARE

Provider Name: _____

Provider NPI Number: _____

Provider Phone: _____ **Provider Fax:** _____

Team Care is the Montana Medicaid lock-in program for clients who have a history of using Medicaid services at an amount or frequency that is not medically necessary. If you would like to refer a client whom you believe is appropriate for Team Care, please provide the following patient data.

Patient Name: _____ ID: _____ Date of Birth: _____

Reason for referral: _____

_____

_____

_____

Patient Name: _____ ID: _____ Date of Birth: _____

Reason for referral: _____

_____

_____

_____

Patient Name: _____ ID: _____ Date of Birth: _____

Reason for referral: _____

_____

_____

_____

Referring Provider Signature: _____ **Date:** _____

Reply to: **Phone: 1-800-362-8312** **Montana Medicaid Help Line**
 Fax: (406) 442-2328 **or** **PO Box 254**
 Helena, MT 59624-0254

For more information about Team Care contact the Medicaid Help Line at 1-800-362-8312 or log on to our website at www.mtmedicaid.org